Treatment

of

Nasopharyngeal Adenoids*

by

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Treatment of Nasopharyngeal Adenoids

Last year at our Section meeting at Denver, during the discussion on the methods of removal of adenoid growths from the vault of the pharynx, I gave my views on the subject at considerable length, but somehow, although referred to in Dr. Mayer's closing remarks, they were not printed at all in the proceedings of our Section, and yet, since that time, I have learned of a number of operators, who, having heard of the discussion, have modified their methods, following in my footsteps. Especially in consequence of this omission, do I desire to present the matter to you in a more formal manner.

These adenoid growths vary considerably in size and consistency, at times occupying the posterior vault only; again the entire central region or extending laterally into the fossæ of Rosenmüller, and even over the Eustachian orifice—in consistency varying from a very soft, spongy, friable mass, to one fibrous, dense, and with firmer resisting outer walls. It must be evident from the location of the growths that the sense of sight can be of little use in the determination of their nature or extent, or in their removal, it being necessary to rely almost exclusively on the sense of touch to give us any accurate knowledge on the subject.

We may examine the nostrils anteriorly by a speculum or posteriorly by the rhinoscopic mirror, but we can not learn much of these growths in this manner with any degree of accuracy, and we always complete our diagnosis by a digital examination, really depend-

ing almost entirely on this examination, which is made by seating the child on a chair, encircling its head with the left arm, and holding it gently but firmly to the left chest while you insert the index finger of the right hand into the mouth back of the soft palate, and thoroughly explore with its tip the entire region. To prevent accidents occurring to the finger, as well as to facilitate the examination, it is necessary, in some way, to protect the first phalanx of this finger, which can be best accomplished by wrapping one or two layers of adhesive plaster about it; over this put two or three turns, doubled, of a two-inch roller bandage, which is made secure by making one turn about the wrist, and as you are about to go around it again, pass the end under the band already in position. This examination is the one on which we accurately rely. It determines the nature of the growth, its location and extent.

You may recall that a year ago I made the statement that in operating on these cases I no longer employ an anæsthetic, unless at the special request of the family physician, as the number of deaths from anæsthesia in these cases has been so considerable that I do not feel that I can bear the responsibility; the condition not being serious enough to take such risks, and the operation is not sufficiently painful to justify it. Whenever necessary, I explain these thoughts to the parents or the physician, discouraging the incurring of the additional danger. I do not pretend to know why operations in this region seem to predispose to fatal results from anæsthesia, but as it is a truth, even though not clearly explainable at present, it must be considered, and no needless risk taken. I apply the same rule to adults, as well as to children.

If you must operate on your patient while he is conscious, you must be prepared to work more rapidly

and as perfectly, or more so,—and without the numerous instruments and appliances you might be allowed to have scattered about were he unconscious;—especially is this true with children, on whom by far the greater number of such operations are performed. With a child, you must win his confidence and retain it throughout the entire work on the nasopharynx. You can not do this if you have an instrument-shop scattered about you on your tables. In consequence of these facts, I early learned the value of the nail of the exploring finger in removing the growths, and in the few cases where the tissues seem so dense that the perhaps damaged or broken natural finger-nail can not remove them, I now use an artificial nail.

I have not seen a case in which I have not been able to reach every part of the post-pharyngeal space with my index finger, which, as you will observe, is not as long as that of many others. I have never seen or rather felt a case of adenoma which has not been entirely removable by my finger-nail, provided the latter was in its normal condition and had not been injured and broken, as is so apt to occur with all of us.

I use the artificial finger-nail as a substitute when, for any reason, my finger is sensitive or painful, or the nail has been broken or damaged, or the nail is too short or irregular. It is readily slipped over the terminal and middle phalanges of the index finger, to which it firmly attaches itself by spring rings, the cutting edge being supported in position by the finger-nail fitting into a recess on the inner side of the knife; it is jointed in structure so that the motion of the phalanges is not limited. The purpose of carrying it over to the middle phalanx is to give it added support and firmness and prevent the possibility of its slipping off while the finger is in the upper pharyngeal space; in this

respect, as well as in a few others, it differs from the artificial finger-nail of Darby, of Capait, L. Browne and others.

While formerly having used various curettes and forceps, especially those of Göttstein and Löwenburg, for the reasons mentioned, I have discarded them all and now for upward of two years have used the simple plan above indicated.

The very fact of there being a very large number of the various instruments used in these operations would indicate to me that their work is not perfect. There are, for instance, the ring knives and curettes of Meyer, Störk, Bosworth, Göttstein, Mackenzie, Hartmann, Delstanche, Pynchon, Seiss, and others, and the forceps of Löwenburg, Gradle, Cohen, Hooper, Major, Casselberry, and others, all of which have their advocates; indeed, some men use several of these instruments at the one operation, of course using them on the anæsthetized patient, as no one could possibly bear such torturing appliances while conscious.

In order to indicate to you how simple the entire proceeding is, I will briefly detail the steps in the operation: A child being brought to the office, presenting any symptoms suggesting adenoid growths, I commence by examining the nose and throat, and then cleanse both thoroughly and yet very gently, all the time getting the child's confidence by coaxing, if necessary, but far more often by a plain statement of facts such as, "This spray will taste better," or "This will be disagreeable, but it won't hurt," or again saying, "Yes, I know it is not pleasant, but it must be done, and it won't hurt." After this is accomplished, I, keeping the child seated on a revolving chair, with arm-rests and back, will lightly put my left arm about the child's head, holding his head against the lower

part of my chest, and then telling him I want to feel something in his throat, I insert the right index finger in the mouth, having in the meantime wrapped the first phalanx with adhesive plaster, putting a turn or two of a two-inch bandage over it, fastening the end at the wrist, I quickly insert it back of and over the soft palate, and explore the entire vault at once; then finding everything favorable, I clasp the head more tightly, bending it forward some over a spittoon, speaking to the child all the time to attract his attention as much as possible from the matter in hand, and then with my finger-nail I proceed to break the envelopes of the enlargements and continue to scrape out all the diseased tissue. When I get over to the region of the Eustachian orifices, unless the swellings be large or very hard, I press on the thickened tissues until I find the contents have entirely escaped; this is done so as to form no contracting cicatrices in this region. I do not leave the cavity until I have either succeeded in removing all of the diseased tissue, or I am convinced that my finger-nail is not strong enough to cope with the form of tissue present, or there is evidence that the blood and detritus are interfering markedly with the child's breathing—these two latter conditions are very unusual in their occurrence, and, should they occur, it means that either the same day or the next, if possible, I will again enter the cavity and, if necessary, with the steel finger-nail, remove every bit of diseased tissue discoverable. The entire operation rarely takes more than two or three minutes, and is followed by very little hemorrhage.

After the operation I clean out the throat and nose carefully, use some soothing ointment in the nose, and advise that liquid albolene be used in the nose and throat at home. Two days thereafter I examine the

region, and if everything is well, I re-examine after a further period of three or four days, when, if healing has been perfect, the upper pharynx will feel smooth and soft, and there will be no danger of recurrence. To my knowledge I have had but one case recur, and that was recently, in the 7-year-old daughter of a physician, on whom, when I operated, I was at a disadvantage in having my finger-nail short and badly curved, my steel finger-nail being at the instrument maker's. A few weeks later I operated again, and this time without recurrence.

In operations by the ordinary methods the finger-examination must invariably be made to verify the diagnosis, and this examination is almost as severe and disagreeable as my operation. Then the child must be anesthetized and subjected to a long operation, which is far more apt to do damage to healthy parts in that region, because there is no feeling touch at the cutting end of the instrument. Then when the operation is supposed to be done, the finger must be used to see whether all the diseased parts have been removed, and the shreds or larger masses remaining must be removed by scraping with the finger or some steel instrument. If with the latter, then another digital examination must be made at once, and then if all is well the child is allowed to come to, and if he recovers from the anæsthetic, he will have a horror of the doctor as well as the doctor's finger being poked into its throat, and the chances are the doctor will presume this case is well and make no further digital examinations, while the condition may recur. I have had quite a number of cases come to me with just such histories, in which recurrence has been the sequel and in whom I have been successful by my method.

In a few words, the method consists in the examination for adenoids by the index finger, and, if discovered, their immediate removal, without general anæsthesia, while the examining finger is in place, by the finger-nail. This failing to remove them, then their removal is to be accomplished by means of my jointed steel finger-nail. This is followed by careful digital examinations of the post-pharyngeal region, about every second or third day for about a week, when, if no growth appears in the cicatrix, recurrence need not be feared. There is but slight bleeding at the time of the operation, and but little pain.

I consider such an operation a natural and common-sense one, and thoroughly surgical in every respect, and it is based on the principles of the thorough and absolute cure of the case in the shortest time possible, with the least inconvenience and danger to the patient and without the slightest possibility of doing damage to the parts operated on. I consider the ordinary operations unsurgical in so far as they subject the patient to unnecessary annoyance and trouble, while at the same time inviting damage to the parts operated on and subjecting the patient to needless danger of an anæsthetic, to which in this special form of disease he is peculiarly susceptible.

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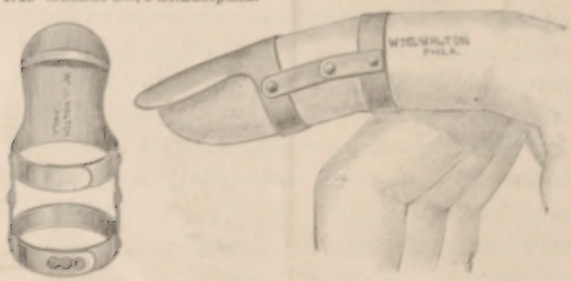

LAUTENBACH'S ARTIFICIAL FINGER-NAIL.